Two Approaches to Achieving Universal Coverage for Delaware

Report to the Health Care Commission

Elliot K. Wicks, Ph.D.

Health Management Associates

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A Single Payer Plan

Eligibility

- Every resident *automatically* covered—except Medicare recipients covered as now
  - Resident is someone residing 18 months in Delaware (6 months for fully employed).
  - New resident could buy in
  - Non-residents working in Delaware could buy in
  - Medicaid/SCHIP eligibles would have same insurance card but separately tracked.

Benefits

- Similar to most widely purchased benefit plan bought now
- Not long-term care
- Medicaid/SCHIP enrollees have coverage at least equal to federally required benefits
- Households could buy private supplemental coverage to extend benefits

Budgeting and Finance

- All payers contribute roughly in proportion as now.
- Employer payroll tax
  - Not on first $20,000 of aggregate payroll
  - Not on individual wages over $100,000
  - All employers withhold premiums and establish Section 125 (cafeteria) plan (to get federal tax benefit for emloyees)
- Household tax/premium applied to gross income minus exemptions used for state income tax
- State and federal maintenance of effort for Medicaid/SCHIP

Budgeting and Finance

- All revenues go to dedicated fund
- “Rainy day” fund to cover economic downturns and unexpected spikes in medical costs
- A global budget established for overall expenditures
- A capital budget cap, probably with additional control on new technologies

Provider payment

- New mechanism should build on the old
- Should be done with provider advisory panel

Administration

- Done by a quasi-independent commission (not in any existing state agency)
- Somewhat independent of political influence (as with Federal Reserve)
  - Members have staggered, long terms of office
- Appointed jointly by governor and legislature

A Massachusetts Style Universal Coverage Plan for Delaware

Plan Elements

- Individual responsibility — mandate
- Employer responsibility — tax with credit for coverage
- Provider responsibility—sales tax
- Major expansion of Medicaid/SCHIP
- State subsidies to make mandated coverage affordable
- Statewide insurance exchange to facilitate purchase of coverage

Individual responsibility

- Everyone required to get coverage or pay penalty = 2/3 cost of minimum coverage plan
- Minimum benefit package defined
- Penalty enforced only if coverage is deemed affordable (with aid of subsidies)

Employer responsibility

- All employers assessed payroll tax = to 75% of average current employer contribution
- Credit against tax for anything spent for employee health care
- Requirement modified for low-wage employers
- All employers must withhold from wages employee's insurance payments
- All employers must establish Section 125 plan (to pay premiums on before-tax basis)

Medicaid-SCHIP Expansion

- Expand coverage up to 300% of poverty for children and 200% for all adults
  - Generates federal revenue that the state would otherwise have to supply
- People eligible for Medicaid/SCHIP who have employer coverage required to accept that coverage, with state “wrap around” and “hold harmless” on premium.

Direct subsidies

- Needed to make affordable for low-income people up to 350% of FPL not eligible for Medicaid/SCHIP
- Tax credit
  - “Advanceable”—Paid in advance of premium due date
  - “Refundable”—Paid even if credit is larger than tax liability
- Amount of subsidy linked to percent of family income spent for health care (from 1% to 10%)

State insurance exchange

- Contract with a number of insurers to offer small number of standard plans
- Adjusted community rating, guaranteed issue
- Required for all individuals and small groups; open to others
- Combine small-group and individual markets
- Individual employee plan choice
- Risk-adjustment for insurers

Financing

- Employer “play or pay”
- Individual premiums
- Provider sales tax: 2% on physicians and 4% on hospitals
- Federal Medicaid/SCHIP match
- Perhaps additional state general revenue